TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
American Casualty Co of Reading PA

MFDR Tracking Number
M4-18-4033-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
June 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the reconsideration based on lack of preauthorization or preauthorization was absent. These medications do not require preauthorization therefore do not need a retrospective review."

Amount in Dispute: $566.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…the Carrier asserts that Provider failed to obtain requisite preauthorization."

Response Submitted by: Brian J Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2017	Pharmacy Services - Compounds	$566.53	$566.53

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. 28 Texas Administrative Code §134.530 sets out prior authorization requirement for pharmacy services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – Precertification/authorization/notification absent
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Is the requestor's position supported?
2. Did the insurance carrier raise new issues?
3. Is the insurance carrier's reason for denial of payment supported?
4. Is the requestor entitled to reimbursement for the compound in question?

Findings

1. The requestor states in their position, "These medications do not require preauthorization therefore do not need a retrospective review." 28 TAC 134.530 (g) states in pertinent part, "Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization **are subject** to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (relating to Medical Payments and Denials), and applicable provisions of Chapter 19 of this title."

2. The respondent states in their position, "Compound medication constitutes a new, non-approved and non-recognized drug and is considered investigational/experimental. Because the compound medication was investigational or experimental in nature and was not accepted as the prevailing standard of care, it required preauthorization."

   28 TAC 133.307 (2)(d)(F) states in pertinent part,

   > The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

   Review of the submitted documentation found insufficient evidence to support the insurance carrier completed a retrospective review and notified the requestor of their findings of investigational and experimental prior to the request for MFDR. The insurance carrier's position will not be considered in this review.

   The respondent also states, "Request for Dismissal as the Requestor has failed to comply with Rules for a proper request for MFDR. THE HCP has not provided a correct, complete bill to the Carrier in either its original submission or in its request for reconsideration."

   Review of the submitted documentation found the insurance carrier processed the claims as submitted. The first explanation of benefits was processed November 16, 2017. The second, April 5, 2018. As such, the insurance carrier did not return the claim based on incorrect or missing information but adjudicated as submitted.

3. The requestor is seeking reimbursement of $566.53 for a compound dispensed October 11, 2017. The carrier denied the disputed compound as treatment not authorized.

   28 TAC §134.530(b)(1)(A) states in pertinent part, that preauthorization is only required for:

   - any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and
   - any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

   The division finds that the compound rendered on the date of service in question does not include a drug identified with a status of "N" in the current edition of the ODG, *Appendix A*. The carrier's denial is not supported. The disputed compound will be reviewed for reimbursement.

4. 28 Texas Administrative Code §134.503 (c) applies to the compounds in dispute and states, in pertinent part:

    (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
    (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
    (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
    (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
    (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or

Drug	NDC	Generic(G) /Brand(B)	Price /Unit	Units Billed	AWP Formula	Billed Amt	Lesser of AWP and Billed
Meloxicam	38779274601	G	$194.67	0.18	$43.80	$35.04	$35.04
Flurbiprofen	38779036209	G	$36.58	4.8	$219.48	$175.58	$175.58
Tramadol	38779237409	G	$36.30	6	$272.25	$217.80	$217.80
Cyclobenzaprine	38779039509	G	$46.33	1.8	$104.25	$83.39	$83.39
Bupivacaine	38779052405	G	$45.60	1.2	$68.40	$54.72	$54.72
						Total	$566.53

The total reimbursement is $566.53. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $566.53.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $566.53, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 21, 2019 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.